

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 56
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.medbd.ca.gov



NOTIFICATION OF NAME CHANGE

Please indicate license typ	e below:				
Physician & Surgeon	Midwife	Spectacle Lens Disp	penser/Contact Lens Disp	penser	
IMPORTANT : The first line of the declaration MUST indicate the name you used prior to your name change,					
<u>DECLARATION</u>					
I, (First)		(Middle)	(Last)	(name prior to change)	
hereby certify that I was originally issued and currently hold license/registration					
number(s)		to practice in the State of California.			
I further certify I have assumed the name of:					
(First)		(Middle)	(Last)		
based on one of the following:					
Court Order	Marriage	Naturalization	Dissolution of Mar	riage	
Other (Specify	r)				
This is my new action for fraudulent pur		or all purposes, and the	is name change has not be	een made	
	* *	•	* *	photocopy of the certified fornia at the address shown	
Marriage Certificate	• Final Diss	olution Decree	Copy of Court Order		
This notification does no	ot generate a d	uplicate certificate.	Please contact the Med	ical Board for an	

BOTH SIDES OF THIS FORM MUST BE COMPLETED

application for a duplicate license, if you wish a certificate reflecting this name change.

PHOTO AREA

PASTE A 2½ X 3½ INCH BLACK AND WHITE OR COLOR PHOTO OF PROFESSIONAL QUALITY HERE.

PHOTO MUST BE OF YOUR HEAD & SHOULDER AREAS ONLY AND MUST HAVE BEEN TAKEN WITHIN THE LAST 12 MONTHS

PROOF/NEGATIVE/ DIGITAL OR POLAROID TYPE PHOTOS ARE NOT ACCEPTABLE

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California that the photo of myself attached hereto, was taken on or about

Applicant's Signature:

TELEPHONE NUMBER

CURRENT MAILING ADDRESS

Address:

My commission expires . SEAL

City:

State:

Zip:

Check here if this is a change of address so that your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address

NOTICE: All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to verify and identify the licensee's identification under Section 2081of the Business and Professions Code. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Licensing Program Chief is the custodian of records. Information in this application may be transferred to other governmental and law enforcement agencies.

AFFIDAVIT

I certify under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of myself, is true and correct and that I am licensed/registered to practice in the State of California.

Applicant's Signature	Date		
	NOTARY		
This individual,, identified as the above individual. Sub,	, has appeared before me, signed in my presence and is oscribed and sworn to before me this day of		
Notary Public's Signature	Telephone Number		
Address			